Medicaid Information Bulletin

January 2005

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
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05 - 01 Health Common Procedure Coding System - 2005 Revisions

Effective for dates of services on or after January 1, 2005, Medicaid begins accepting the 2005 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 2005 Physicians' Current Procedural Terminology (CPT) codes. You must continue to obtain prior authorization required for procedures on the 2004 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 2005 list.

For services on and after January 1, 2005, providers must use the 2005 HCPCS codes. 2004 HCPCS codes discontinued in 2005 may only be used for dates of service prior to January 1, 2005. If you have a question concerning billing the 2005 HCPCS codes, please contact Medicaid Information. ☐

05 - 02 Reminder of Physician Responsibility for Prior Authorization When Required

When a prior authorization is required for a Medicaid medical or surgical health care service, it is the responsibility of the physician to obtain the prior authorization from the Division of Health Care Financing, Utilization Management Unit BEFORE service is rendered to the patient. The physician must be the one to obtain the prior authorization because the physician has basic responsibility for the patient, for establishing a diagnosis, and outlining the medical necessity indications for the requested service. *Current Procedural Terminology* (CPT) codes, developed by the American Medical Association for physicians to describe medical/surgical procedures for billing purposes, are those on which the need for a prior authorization is determined. An exception to prior authorization may be warranted if circumstances fall into one of the categories of exception/limitation for retroactive review described in SECTION 1, Chapter 9 - 7 of the Utah Medicaid Physician Provider Manual. The physician retains the responsibility to request a retroactive review and authorization when exception criteria are met. A prior authorization or retro review can neither be requested by nor given to a hospital or any other provider if the patient's physician fails to provide the necessary information and obtain the necessary authorization for a service. Changes have been made in the Physician Provider Manual to clearly state the physician responsibility for prior authorization. The updated pages are available.

This physician responsibility is currently clearly stated in the Hospital Manual on the introductory pages of the Hospital Surgical Procedures List. ☐

05 - 03 Coding Issues and/or corrections

Coding Issues for Update and Review:

Anesthesia
When billing anesthesia services using the Physical Status Modifier codes P1 through P6, P1 will be the expected code for anesthesia required in labor and delivery. Labor and delivery in a normal healthy individual does not warrant a higher P status code. P2 should only be used when there is "systemic disease" effecting labor/delivery such as preeclampsia or a medical condition like seizure disorder which may complicate or compromise the delivery or condition of mother or infant. Cases where P2 is used for a normal delivery will be reviewed and money will be recovered when there is not sufficient documentation to support medical indications for the higher physical status level.

Laboratory
Code 87804 QW should be billed for influenza screening completed by the physician. The code 87804 QW replaces the unspecified code 87899 and the multiple step method code 87449 QW which will no longer be accepted in Medicaid for influenza screening.

Code 82274 was recently approved through CLIA with the QW modifier. However, the code 82274 is a non-covered code in Medicaid and will continue as a non-covered code. For occult blood testing in stool, the code 82270 is the correct code to use.

When the codes 88142, 88143, 88174, and 88175 for cytopathology are billed together or in any combination, only one of the four codes will be paid.

Imaging
Codes that are listed as not a covered benefit in the CPT list should not be open in the professional component; these codes will be closed as they are identified. An example of this is code 76005–Fluoroscopy for guidance during injection or other procedure. This code was opened in the professional component and will be closed. The American Academy of Orthopedic Surgery and the American College of Radiology agree intraoperative supervision positioning, and interpretation of imaging or monitoring equipment by the operating surgeon or assistant surgeon is inherent in the procedure code and should not be separately reimbursed. The editing program follows these edits and will deny code 76005 or 76003 when billed by the physician preforming the primary procedure requiring fluoroscopy. Code 76005 will be open in the base code for physicians in offices to bill the technical service. As per CMS guidelines, the code is not open for independent radiology hospital or ambulatory surgery centers.

When MRI, CT, or PET imaging procedures are requested more than once in a year for the same anatomical area, medical record documentation must support the necessity of repeating the procedure. Prior approval may be denied for an MRI related to a musculoskeletal problem when the patient has not followed through with the prescribed conservative therapy regimen, including physical therapy appointments. Repeated examinations are subject to post payment review of the medical record documentation.

EMG testing
The codes 95860 through 95872 EMG testing are covered as professional services only in Medicare. In the Medicaid system, when a code has only one component the base code should be billed without a modifier. Somehow this range of codes has been opened in the technical and professional components and there is not a technical component. Therefore, as of January 1, 2005, bill the base code 95860 through 95872 without the modifier 26 for payment. For consistency Medicaid has always allowed payment of the base code without a modifier when there is only a technical or professional component for the service.

Orthopedic procedures
The code 20930, code 20936, and code 22841 will no longer require prior authorization. These codes under the correct coding initiative are B status bundled codes which may not be paid separately when submitted with some procedures.

Botox Injections
The injection procedure for Botulinum type A treatment of laryngeal spasm will be covered under code **S2340** and **S2341**. See the injectable medications criterion for Botulinum Type A.

Neonatal Care
Medicaid policy supports payment of physician attendance at the delivery of a critical newborn. Therefore, payment of code 99436 and 99295 on the same date of service is covered. Medicaid follows the recommendations of the correct coding initiative and the editing program which follows CPT guidelines. Payment for code 99440 is considered included within code 99436 and 99295. However, the code 99440–newborn resuscitation may be reviewed for payment in critical care newborns requiring multiple resuscitation efforts outside of the delivery room.

CPT Codes Covered (Descriptors in list below may be abbreviated, as indicated by repeated dots . . . .)

00561 . . . with pump oxygenator under one year of age
11004 Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; . . . .
11005 . . . Abdominal wall, with or without fascial closure
11006 . . . External genitalia, perineum and abdominal wall, with or without fascial closure
11008 Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (add on)
19296 Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, ...
19298 Placement of radiotherapy afterloading bradytherapy catheters (mutiple tube and button type) into breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
20982 Ablation, bone tumors, radiofrequency, percutaneous, including computed tomographic guidance
31545 Laryngoscopy direct, operative with operating microscopy or telescope, ...
31546 . . . reconstruction with graft(s) (includes obtaining autograft)
31620 Endobroncial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)
31636 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; . . . .
31637 . . . Each addition major bronchus stented (add-on)
31638 . . . with revision of tracheal or bronchial stent inserted at previous session . . . .
32019 Insertion of indwelling tunneled pleural catheter with cuff
36818 Arteriovenous anastomosis, open, by upper arm cephalic vein transposition
44137 Removal of transplanted intestinal allograft, complete
45391 Colonoscopy, rigid or flexible, proximal to splenic flexure; with endoscopic ultrasound examination
45392 . . . with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

50391 Instillation(s) of therapeutic agent into renal pelvics and/or ureter through established nephrostomy, pyelostomy, or ureterostomy tube (ie. anticarcinogenic or antifungal agent)
57267 Insertion of mesh or other prosthesis for repair or pelvic floor defect,. . . .
57283 Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)
66711 . . . cyclophotocoagulation, endoscopic
76077 DXA bone density study one or more sites; vertebral fracture assessment
76510 Opthalmic ultrasound, diagnostic; B-scan and quanitative A-scan performed at the same patient encounter (subject to criterion#35B and correct coding initiative edits.)
76820 Doppler velocimetry, fetal; umbilical artery
76821 . . . middle cerebral artery
78811 Tumor imaging, positron emission tomography (PET); limited area (i.e. chest, head/neck)
78812 . . . skull base to mid thigh
82045 Albumin; ischemia modified
84163 Pregnancy associated plasma protein-A (PAPP-A)
86064 B cells; total count
86379 Natural killer (NK) cells, total count
88174 Cytopathology, cervical or vaginal, automated think layer preparation, screening by automated system, ...
88175 . . . with screening by automated system and manual rescreening , under physician supervision.
88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only first marker
88185 . . . each additional marker (add-on)
88187 Flow cytometry, interpretation; 2 to 8markers
88188 . . . 9 to 15 markers
88189 . . . 16 or more markers
92620 Evaluation of central auditory function, with report; initial 60 minutes
92621 Evaluation of central auditory function, with report, each additional 15 minutes Limited to 2 units or 30 minutes
92625 Assessment of tinnitus (includes pitch, loudness, matching, and masking)
93745 Initial set-up and programming by a physician of wearable cardioverter-defibrillatory . . . .
93890 Transcranial Doppler study of the intracranial arteries; vasoreactivity study
97597 Removal of devitalized tissue from wound(s), selective debridement, without anesthesia,. . . .
97598 . . . total wound surface area greater than 20 square centimeters

CPT Codes Covered with Prior Authorization (Descriptors in list below may be abbreviated.)

52402 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
PRIOR APPROVAL: Telephone ICD-9: 63.93 . . . . . Refer to Criteria #10
58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when preformed
PRIOR APPROVAL: Telephone ICD-9: 68.23 . . . . . Refer to Criteria #13[2]
58956 Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
PRIOR APPROVAL: Telephone ICD-9: 68.4 . . . . . Refer to Criteria #14[2]
63050 Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;
PRIOR APPROVAL: Telephone ICD-9: 03.09 . . . . . Refer to Criteria #1
63051 . . . with reconstruction of the posterior bony elements . . . .
PRIOR APPROVAL: Telephone ICD-9: 03.09 . . . . . Refer to Criteria #1
63295 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (add-on)
PRIOR APPROVAL: Telephone ICD-9: 03.09 . . . . . Refer to Criteria #1
63685 Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, ...
PRIOR APPROVAL: Written ICD9-: 03.93 . . . . . Refer to Criteria #32C
73721 Magnetic resonance imaging lower extremity joint (knee)
PRIOR AUTHORIZATION FOR AGE 20 AND OLDER: Telephone ICD-9: 88.94 . . . . . Refer to Criterion 40B
73722 ... with contrast material (knee)
PRIOR AUTHORIZATION FOR AGE 20 AND OLDER: Telephone ICD-9: 88.94 . . . . . Refer to Criterion 40B
73723 without contrast followed by contrast (knee)
PRIOR AUTHORIZATION FOR AGE 20 AND OLDER: Telephone ICD-9: 88.94 . . . . . Refer to Criterion 40B
95811 Polysomnography; sleep staging with 4 or more additional parameters of sleep, ...
PRIOR AUTHORIZATION THROUGH UR COMMITTEE . . . . . Refer toCriterion 43

CPT Codes Non-Covered (Descriptors in list below may be abbreviated.)

27412 Autologous chondrocyte implantation, knee
27415 Osteochondral allograft knee open
29866 Arthroscopy knee surgical; osteochondral autograft(s) (ie. mosaicplasty) (includes harvesting of the autograft)

29867 . . . osteochondral allograft (ie. mosaicplasty)
29868 . . . meniscal transplantation (includes arthrotomy for meniscal insertion), medical or lateral
32855 Backbench standard preparation of cadaver donor lung allograft prior to transplantation, ...
32856 . . . bilateral
33933 Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, ...
33944 Backbench standard preparation of cadaver donor heart allograft prior to transplantation, ...
34803 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; . . . .
36475 Endovenous ablation therapy of incompetent vein, extremity, ...
36476 second and subsequent veins treated in a single extremity, each through separate access sites (add-on)
36478 Endovenous ablation therapy of incompetent vein, extremity, ...
36479 second and subsequent veins treated in a single extremity, each through separate access sites (add-on)
37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous, ...
37216 . . . without distal embolic protection
43257 Upper gastrointestinal endoscopy . . . as appropriate; . . . .
43644 Laparoscopy, surgical, gastric restrictive procedure; . . . .
43645 . . . with gastric bypass and small intestine reconstruction to limit absorption
43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy . . .
44715 Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, ...
44720 Backbench reconstruction of cadaver or living donor intestine allograft prior to transplantation, ...
44721 . . . arterial anastomosis, each
46947 Hemorrhoidopexy (i.e. for prolapsing internal hemorrhoids) by stapling.
47143 Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, ...
47144 . . . with trisegment split of whole liver graft into two partial liver grafts (. . . .
47145 . . . with lobe split of whole liver graft into two partial liver grafts (i.e. left lobe (segments II, III, and IV) . . . .
47146 Backbench reconstruction of cadaver or living donor liver graft prior to allotransplantation, venous anastomosis,
47147 . . . arterial anastomosis, each
48551 Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, ...
48552 Backbench reconstruction of cadaver donor pancreas allograft prior to transplantation, venous anastomosis, each
50323 Backbench standard preparation of cadaver donor renal allograft prior to transplantation, ...
50325 Backbench standard preparation of living donor renal allograft (open or laparoscopic) . . . .
50327 Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation, venous anastomosis,
50328 . . . arterial anastomosis, each
50329 . . . ureteral anastomosis, each
58565 Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
78813 PET, whole body
78814 Tumor imaging, positron emission tomography (PET) . . . . .
78815 . . . skull base to mid thigh
78816 PET with concurrent CT, whole body
79005 Radiopharmaceutical therapy by oral administration
79101 Radiopharmaceutical therapy by intravenous administration
79445 Radiopharmaceutical therapy, by intra-arterial particulate administration
82656 Elastase, pancreatic (EL-1), fecal, qualitative or semi-quantitative
83009 Helicobacter pylori, blood test analysis for urease activity, non-radioactive isotope (i.e. c-13)
83630 Lactoferrin, fecal, qualitative
84166 Protein; electrophorectic fractionation and quanitation, other fluids with concentration (i.e. urine, CSF)
86335 Immunofixation electrophoresis; other fluids with concentration (i.e urine, CSF)
86587 Stem cells (i.e. CD 34) total count
87807 Infectious agent antigen detection by immunoassay with direct optical observation; respiratory syncytial virus
88360 Morphormetric analysis, tumor immunohistochemistry . . . .
88367 Morphormetric analysis, in situ hybridization, (quanitative or semi-quanitative) . . . .
88368 . . . manual
90465 Immunization administration under 8 years of age . . . .
90466 . . . each additional injection
90467 Immunization administration under age 8 (. . . .
90468 . . . each additional administration (single or combination vaccine/toxoid) per day (add-one)
90656 Influenza virus vaccine, split virus, preservative free, for use in individual 3 years and above, for IM use
91034 Esophagus, gastroesophageal reflux test; . . . .
91035 . . . with mucosal attached telemetry pH electrode placement, recording, analysis, and instrumentation
91037 Esophageal function test, gastroesophaeal reflux test . . . .

91038 . . . prolonged (greater than 1 hour, up to 24 hours)
91040 Esophageal balloon distension provocation study
91120 Rectal sensation, tone, and compliance test (i.e. response to graded balloon distention)
93892 Transcranial Doppler study of intracranial arteries; emboli detection without intravenous microbubble injection
93893 . . . emboli detection with intravenous microbubble injection
94452 High altitude simulation test (HAST) , with physician interpretation and report
94453 . . . with supplemental oxygen titration
95928 Central motor evoked potential study (transcranial motor stimulation); upper limbs
95929 . . . lower limbs
95978 Electronic analysis of implanted neurostimulator pulse generator system . . . .
95979 . . . each additional 30 minutes after first hour (add-on)
97605 Negative pressure wound therapy (i.e. vacuum assisted drainage collection), ...
97606 . . . total wound service grater than 50 square centimeters.
97810 Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes . . . .
97811 . . . each additional 15 minutes of personal one on one contact with the patient, with re-insertion of needle(s)
97813 Acupuncture, one or more needles; with electrical stimulation, initial 15 minutes . . . .
97814 . . .each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)

HCPCS 2005 Long Description Changes

32850, 33930, 33940, 43846, 44132, 44133, 47140, 48550, 50300, 50320, 50547, 61885, 63685, 64590, 75960, 76827, 77418, 78267, 83013, 83014, 89346, 90700, 96111, 99293, 99294, 99295, 99296.

HCPCS 2005 Discontinued Codes

G0292 Administration of experimental drug in a Medicare qualifying clinical trial
92589 Central Auditory Function Test(s) (Specify)
97780, 97781 Acupuncture, one or more needles; with electrical stimulation

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05 - 04 CPT Codes Non-Covered for Assistant Surgeon

Codes in the 7000, 8000, and 9000 range which would not reasonably apply to an assistant surgeon are not included in this list. Some codes included in the list fit into this category and have been deleted from the list because they are codes which do not logically apply to an assistant surgeon. There are also some discontinued codes which were identified and have been removed. These deleted codes include:

71551	71552	72195	72197	73206	73218	73219	73222	73223	73706	73718	73719	73722	73723
74182	74183	75900	76873	77427	77520	77523	78647	80048	80053	80069	80074	80076	80197
81020	82300	82523	83516	83902	84156	84157	84302	84484	84591	85055	85461	86001	86301
86316	86406	86617	87300	87451	87660	89225	89230	89235	89240	89321	90940	92548	92587
92588	92612	92614	93270	93271	93272	93668	93727	95921	95922	95923	95957	97032	97033
97034	97035	97036	97113	97150	97602	97750	97802	97803	97804	99170	99172		

Codes added to the Non-Covered Assistant Surgeon List include:

11005	11008	19296	19297	19298	20982	31620	31636	31637	31638	32019	36818	45391
45392	50391	52402	52450	58356	66711	76003	76820	76821	93307	93308	93312	93745
93890	95978	95979	97597	97598	97601							

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05 - 05 Diagnosis Codes Covered for Emergency Only Client

066.41 West Nile Fever with encephalitis
070.71 Unspecified viral hepatitis C with hepatic coma
453.40 Venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.41 Venous embolism and thrombosis of deep vessels of proximal extremity
453.42 Venous embolism and thrombosis of deep vessels of distal lower extremity

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05 - 06 Diabetes Self Management Training

The Center for Medicare and Medicaid Services (CMS) has provided approval to add the pharmacist as a provider type to provide diabetes self management training. To obtain a group practice number through Medicaid, at a minimum two of the three provider types (nurse, dietitian, and pharmacist) must teach the program for Medicaid diabetes self-management. All three provider types (pharmacist, nurse, and dietician) must be certified diabetes educators or have completed a recent course in diabetes consisting of a minimum of 24 hours of approved continuing diabetes specific education covering the 15 core content areas recommended by the ADA in order to receive approval as an instructor in the program through the Utah State Health Department Chronic Diabetes Program. After completion of the original 24 hours, instructors must complete a minimum of 6 hours of continuing education each year. Proof of Utah State license and certification of diabetic specific education must be submitted by each of the instructors to Medicaid Operations to obtain a provider number as a program group practice. ☐

05 - 07 Psychiatric Evaluations

Psychiatric evaluations are requested by the Department as part of the prior authorization process for patients who request specialty medical or surgical procedures. The Physician Manual, SECTION 2, page 27, Item "M" outlines the requirements for a psychiatric evaluation when one is required. Elements of the evaluation and the written report are based on standardized elements developed in cooperation with CMS (formerly HCFA) and the American Psychological Association (ASA). The Medicaid Utilization Review Committee has developed additional elements of the evaluation expected to be included in the medical record information reported. The additional elements include patient commitment and support system components. Billing issues are also clarified.

Commitment of patient to comply with treatment is crucial to many surgical procedures. To demonstrate the patient's commitment, a) Assess and report the patients motivation to comply with the long term followup of the procedure under consideration. Review and report medical and social history issues of failure to keep medical appointments, leaving the hospital against medical advice, and evidence of compliance issues with prior medical treatments. b) Assess and evaluate patients' current lifestyle, attitude and degree of determination/motivation to make the long term life style changes. For example: Discussion and evaluation for a patient requiring surgery for weight loss should include the patients plan for **1**) daily exercise based on current physical abilities, **2)** awareness of eating triggers, and knowledge that eating as a coping mechanism could cause serious post-operative complications. Knowledge of a healthy diet regimen and/or need for nutritional counseling should also be part of the discussion. **3)** The evaluation should also include the patient's understanding of the effect tobacco, alcohol and/or drug use will have on surgical outcome including need to discuss medication change with physician, and/or quit habits which are adverse to surgical outcome, and **4)** willingness to continue supervised behavior modification therapy for at least one year.

Support system: evaluate and report the patients family and social history, current family support, social network, awareness of community resources and willingness to participate as a team member in the effort to maintain successful surgical outcome (weight loss, organ transplant regimen)

Billing
Psychiatric examinations authorized through UR committee staff physicians will be covered using code 99245 with modifier 22. ☐

05 - 08 Additions to Criteria for Medical and Surgical Procedures

MRI of Knee added to section after spine in Criterion #40B

Knee
Clinical examination and plain x-ray films are still the gold standard for evaluation and management of the knee. MRI should not be used as a routine screening tool in all knee injuries. It should be used only when the diagnosis remains in doubt. It does not replace clinical evaluation and management, and multiple view-x-rays as primary diagnostic tools.

Indications
A. Detection, staging, and post-treatment of knee tumor
B. Suspected osteomyelitis, avascular necrosis, or occult or soft tissue tumor
C. Persistent knee pain secondary to an injury which is not responding to conservative treatment when there is joint effusion/swelling, limited range of motion (ROM), and acute muscle spaces and/or instability which limit clinical evaluation. Conservative therapy includes rest, ice, compression, elevation, non-steroidal antiinflammatory drugs (NASAID's), crutches, and ROM exercises. Multiple view x-rays have ruled out fracture or loose body in the knee and the clinical picture remains unclear.
D. Persistent knee pain/swelling and/or instability without an associated injury which is unresponsive to at least 3 weeks of conservative treatment and after multiple view x-rays the diagnosis remains unclear.
E. Multiple ligament injury or recurrent ligament injury after surgery
F. Staging of osteochondritis dissecans (OCD) lesions.

Limitations
A. Non-covered when used to diagnose or evaluate rheumatoid arthritis or degenerative joint disease.
B. Non-covered when the clinical examination diagnoses torn meniscus, loose body, or osteochondritis dessicans **and** arthroscopy or ligament reconstruction is planned. MRI should only be considered if there are clinical indications that the MRI will likely change or improve the planned treatment, excluding other treatment of neuropathic processes.
C. Non-covered when there is persistent true locking of the knee which indicates a torn meniscus or loose body. True locking is defined as more than a momentary locking of the joint with the knee in a fixed position, as compared with the sensation of momentary catching with extension of the knee.

Sleep Study for an Adult Criteria #43

Sleep studies have been a non-covered service under Medicaid subject to utilization committee review when there is strong evidence of medical necessity. Prior to considering that a patient should be referred for polysomnography or to a sleep specialist, the referring physician must submit the following information to the Utilization Review nurses for presentation to the UR committee. The UR committee will continue to determine if the case meets criterion requirements for medical necessity and make the recommendation for or against prior authorization. Documentation of all items in section A must be addressed and applicable items must be submitted as follows before consideration of section B:

A. 1. The patient should receive a thorough history, physical examination, and medical evaluation through their referring physician, internist, or pulmonologist. It is expected that the evaluation will include a sleep questionnaire and a sleep log covering 7-14 days. Documentation of the conservative measures recommended and/or attempted must be provided, including:
   a. Change in sleep position for those who have problems sleeping supine, including measures taken to ensure the patient sleeps on their side.
   b. Weight loss efforts have been made; what were the efforts and over what period of time?
   c. Medications have been tried to relieve nasal obstruction, deal with insomnia, deal with depression and/or presence of pain.
   d. Review list of prescription, OTC, and herbal treatments (i.e. some antidepressants, stimulants, bronchodilators, xanthines, decongestants, diuretics, histamine antagonists, antihypertensives, steroids, caffeine, and nicotine may cause sleep disorder).
   e. Medical disease and syndromes diagnosed and under treatment
   f. Patient has been informed evening alcohol intake must be avoided
   g. Review sleep hygiene such as timing of diet (i.e hot spicy or fatty food, caffeine), exercise, and viewing violent or disturbing movies or TV programs
   h. If there is evidence of obstruction, has an oral appliance been tried?

2. When initial conservative measures have failed and anatomy of neck, throat, or chin indicates an ENT reason for obstructive sleep apnea, an otorhinolarynologist should be consulted. The ENT may be able to fit the person with an oral or dental appliance which resolves the problem. If an ENT problem is suspected and the nature of the anatomic deformity is not obvious to the otorinolaryngologist , a sleep study should be completed in an attempt to identify the nature of the collapse or narrowing during sleep. Research indicates that any one surgical procedure may not correct the problem. A sleep study with a CPAP trial should be completed prior to any of the following surgeries to see if the obstruction will resolve without surgery, including:
   - uvulopalatoplasty with or w/o tonsillectomy
   - laser midline glossectomy and lingualplasty
   - inferior sagittal osteotomy & genioglossal advancement with hyoid motomy/suspension
   - tracheotomy

3. If consideration for sleep study enrollment is based on daytime sleepiness or lack of restful sleep, a psychiatric evaluation should be completed first. Medication review should determine if there are sedative side effects in current medications. The patient should be evaluated for depression or a stress anxiety disorder. Psychiatric evaluation should assess whether the patient's compliance history and attitude suggest they would be compliant with the sleep disorder treatment plan and use of CPAP. Even patients with suspected narcolepsy should receive a psychiatric evaluation to assess for pseudo narcolepsy.

4. When coronary problems in an overweight person are suspected, a cardiovascular work up is suggested.

5. Complete laboratory study to rule out hypothyroidism.

B. **Basic criteria** for sleep study in Suspected Apnea after evaluating for causes listed in section "A" and a trial of conservative treatment.

1. **One** of the following conditions must be present:
   Witnessed apnea or choking spells during sleep
   Morning headaches which resolve one to two hours after awakening in morning
   Excessive/persistent daytime sleepiness: pharmacology & psychiatric evaluation has ruled out easily manageable causes and the Epiworth scale must confirm excessive daytime sleepiness.

   AND ONE (2, 3, or 4)

2. When a request for polysomnography is based on a night time pulse oximetry study, the results must meet one of the following (a, b, or c) guidelines:
   a. The oxygen saturation must fall at least 4% or greater below the baseline level **and** the mean O_2 level based on a full nights sleep must be 90% or less with an oxygen saturation less than 85% a minimum of twenty times during the night time pulse oximetry study. The baseline level is the level taken during waking hours before the sleep study is initiated. For example a chronic obstructive pulmonary disease (COPD) patient with a baseline of 86% is not eligible of a sleep study when the mean O_2 during sleep study is 84%.
   b. If the patient's baseline oxygen saturation level is 74 or greater, the patient may also be considered a suitable candidate for a sleep study if they have **one** episode of apnea where the O_2 saturation is 70% or less.
   c. Apnea-Hypopnea Index (AHI) is greater than or equal to 15.

3. When a request is based on the fact that the person carries excessive weight about the neck and chin, the person must have a BMI $\geq$ 29 and hypertension.

4. ENT surgery is anticipated from the list discussed in item A2.

NOTE: When apnea is identified during a hospitalization every attempt should be made to preform polysomnography prior to patient discharge from the hospital. When a sleep study is approved for an outpatient evaluation, the approval includes the expectation for a CPAP trial which will be approved under code 95811.

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05 - 09 Free Breast and Cervical Cancer Screening

Do you know women that can't afford to have a mammogram? The Utah Department of Health's, Cancer Control Program offers free breast and cervical cancer screening to qualifying women. Screening services are available at over 50 locations statewide and include a Pap test, a pelvic examination, a clinical breast exam, and a voucher for a free mammogram. In addition to screening services the Utah Cancer Control Program refers qualifying women, diagnosed with breast or cervical cancer, to Medicaid for treatment. For more information or to find the screening locations nearest you visit www.utahcancer.org or call 1(800) 717-1811. ☐

05 - 10 Dental Ambulatory Surgical Facilities Costs

Code 21299 which has been used to bill for facility charges for ambulatory surgical dental cases is changed. Beginning January 1, 2005, please bill using code 41899. This code is currently used by most insurance carriers for facility charges for ambulatory surgical dental services and this change will make Medicaid more consistent with other insurance carriers.
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05 - 11 Dental Codes Changes, HCPCS 2005

Descriptors for the following codes are changed by HCPCS 2005: D4210, D7111, D7286.

Code D7281, Surgical exposure of impacted or unerupted tooth in order to aid eruption is discontinued effective January 1, 2005. ☐

05 - 12 Medical Supplies

New Open Codes

E0621, Sling or seat, patient lift, canvas or nylon, (replacement for patient owned lift)
E1090, High strength lightweight wheelchair, detachable arms desk or full length, swing away detachable foot rests.
A6507. Compression burn garment, foot to knee, custom fabricated
A 5119, Skin barrier, wipes, box per 50 ostomy use only. Limited to two boxes per month.
L3805, wrist hand finger orthosis, long
E0194, Air fluidized bed, is replacing codes Y6000, Air fluidized bed with micro crystals and Y6009, Air fluidized bed.

Closed codes

K0014, other motorized/power wheelchair base, is closed beginning January 1, 2004.

Revisions

E0471, Respiratory Assist Device, bilevel pressure capability, with backup rate feature is changed from a capped rental (modifier LL) back to a rental (modifier RR) beginning January 1, 2005. E0470, Respiratory assist device, without backup rate feature and C-pap, E0601, and , Humidifier, E0562 continue to be capped rental (modifier LL) and may bill with a MS each six months for maintenance.

Code A7035, Headgear used with positive airway pressure device, patient owned. New limitation allows one per 6 mos.
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05 - 13 Medical Supplies Coding Changes, HCPCS 2005

(Descriptors may be abbreviated, as indicated by repeated dots . . . .)

Opened codes

E0639, Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories.
E0463, Pressure support ventilator with volume control mode, may include pressure control mode, ...
E0464, Pressure support ventilator with volume control mode, may include pressure control mode, ...
E2605, Positioning wheelchair seat cushion, width less than 22 inches, any depth
E2606, Positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2618, Wheelchair accessory, solid seat support base (replaces sling seat), for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware
E2291, Back. planar, for pediatric size wheelchair including fixed attaching hardware
E2292, Seat, planar, for pediatric size wheelchair including fixed attaching hardware
E2293, Back, contoured, for pediatric size wheelchair including fixed attaching hardware
E2294, Seat, contoured, for pediatric size wheelchair including fixed attaching hardware
E2368, Power wheelchair component, motor, replacement only
E2369, Power Wheelchair component, gear box, replacement only
E2370, Power wheelchair component, motor and gear box combination, replacement only

Discontinued codes and replacements

A4521, A4522, A4523, A4524, A4525, A4526, A4527, A4528, A4529, A4530, A4531, A4532, A4533, A4534, A4535, A4536 are discontinued and replaced with
T4521, Adult-Sized incontinence product, Brief/Diaper, Small, Each
T4522, Adult-Sized incontinence product, Brief/Diaper, Medium, Each
T4523, Adult-Sized incontinence product, Brief/Diaper, Large, Each
T4524, Adult-Sized incontinence product, Brief/Diaper, Extra Large, Each
T4529, Pediatric sized disposable incontinence product, Brief/Diaper, small/medium size, each
T4530, Pediatric sized disposable incontinence product, Brief/Diaper, large size, each
T4533, Youth-sized disposable incontinence product, Brief/Diaper, each
T4535, Disposable liner/shield/guard/pad/undergarment for incontinence, each
T4536, Incontinence product. Protective underwear/pull-on, reusable any size, each . . . . .
A4324, Male external catheter, with adhesive coating, and
A4325, Male external catheter, with adhesive strip, each, and
A4347, Male external catheter with or without adhesive, ...; are discontinued and replaced with:
A4349, Male external catheter, with or without adhesive, disposable, each
A4610, Tracheal suction catheter, closed system, for more than 72 yours of use, each is discontinued and replace with
A4605, Tracheal suction catheter, closed system, each
K0081, Wheel Lock Assembly is discontinued and replaced with
E2206, Manual wheelchair accessory, wheel lock assembly, complete, each
K0656, Skin Protection Wheelchair seat Cushion, less than 22 inches, any depth (gel cushion) is replaced with
E2603, Skin protection wheelchair seat cushion, with less than 22 inches, any depth
K0657, Skin Protection Wheelchair seat Cushion, 22 inches or greater, any depth (gel cushion) is replaced with
E2604, Skin protection wheelchair seat cushion, with 22 inches or greater, any depth
K0662, Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, includes mounting hardware is replaced with
E2613, Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, ... ; and
E2615, Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height . . . .
K0663, Positioning wheelchair back cushion, posterior, width greater than 22 inches, any height, ... is replaced with
E2614, Positioning wheelchair back cushion, posterior, width less than 22 inches or greater, any height, ...; and
E2616, Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches or greater, ...
K0114, Back Support System, Wheelchair and
K0023, Solid back insert, planar back, single density foam is replaced with
E2620, Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches . . . . .
E2621, Positioning wheelchair back cushion, planar back with lateral supports, ...
L0500, Lumbar-sacral-orthosis (LSO), Flexible (lumbo-sacral support) is replaced with
K0637, Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, ...

L0510, LSO, flexible (lumbo-sacral support), custom fabricated is replaced by
K0638, Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, ...
L0600, Sacroiliac, flexible (sacroiliac surgical support) is replaced by
K0630, Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint; and
K0632, Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels . . . ..
L0610, Sacroiliac, flexible (sacroiliac surgical support), custom fabricated.
K0631, Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, ...
K0633, Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels . . . . .

Discontinued Codes

E0176, Air pressure pad or cushion, nonpositioning
E0178, Gel pressure pad or cushion, nonpositioning
E0179, Dry pressure pad or cushion, nonpositioning
E0192, Low pressure/positioning equalization pad, wheelchair
B4151, Enteral formula, natural intact protein/protein isolates, ...
B4156, Enteral formula: category VI: standardized nutrients, ...
E0454, Pressure, ventilator with pressure control, pressure, support and flow triggering feature
L0520, LSO, anterior-posterior-lateral control (Knight, Wilcox types), with apron front

Codes with descriptor changes

A4222, A5119, B4150, B4152, B4153, B4154, B4155, E0450RR, E0461, E0951, E0952, E0955, E0956, E0957, E0967, E0978, L2036, L2037, L2800

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05 - 14 Physical Disabilities Waiver Provider Manual

A revised manual for the Medicaid 1915c Home and Community-Based Services Waiver for Individuals with Physical Disabilities (Physical Disabilities Waiver) has been published. The revised manual provides information consistent with the July 1, 2003 amended version of the Waiver Implementation Plan approved by the Centers for Medicare and Medicaid Services. ☐

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05 - 15 DD/MR Waiver Provider Manual

A revised manual for the Medicaid 1915c Home and Community-Based Services Waiver for Individuals with Developmental Disabilities and Mental Retardation (DD/MR Waiver) has been published. The revised manual provides information consistent with the July 1, 2003 version of the Waiver Implementation Plan approved by the Centers for Medicare and Medicaid Services. ☐

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05 - 16 Attention: Pharmacy Providers

Utah Medicaid pharmacy claim data indicates some pharmacies are billing with an incorrect prescriber identifier. Medicaid requires the correct physician's name or Medicaid prescriber license number for each prescription. Recent reviews of the prescriber information has shown some pharmacy providers are using one identifier for all Medicaid prescriptions. Providers sending incorrect data will be referred to the Provider Integrity Unit for further review and follow up.

Contact your software vendor for assistance in sending the correct identifier. ☐

05 - 17 Attention: DHS Contracted Mental Health Providers

Corrections have been made to the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors:

In Chapter 1-3, Definitions, the definitions of diagnostic services and rehabilitative services have been rewritten to better reflect the definitions contained in 42 CFR 440.130. In Chapter 1-4, Qualified Mental Health Providers, corrections have been made in how qualified providers are identified. In Chapter 1-6, Billing Arrangements, clarifications on how mental health centers bill for services have been added, and on how to bill services given to subsidized adoptive children exempted from the Prepaid Mental Health Plan for outpatient mental health care. In Chapter 2-5, Group Psychotherapy, the qualifications of the group co-leader have been clarified.

Providers will find attached an updated SECTION Two of the provider manual.
A vertical line in the margin is next to the text that has been changed.
Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

05 - 18 Attention: Licensed Psychologists

Corrections have been made to the Utah Medicaid Provider Manual for Psychology Services:

In Chapter 1-1, General Policy, clarifications were added on providing psychology services to foster care children or subsidized adoptive children who have been exempted from the Prepaid Mental Health Plan and who are in a residential treatment program.

In Chapter 2-5, Group Psychotherapy, the qualifications of the group co-leader have been clarified.

Psychologists will find updated pages with corrections to these chapters. A vertical line in the margin is next to the text that has been changed.

Contact Merrila Erickson at 538-6501 or merickson@utah.gov if you have any questions. ☐

05 - 19 Repairs for Hearing Aids

Medicaid reimburses code V5014 for hearing aid repairs. If the repair was sent out of vendor's facility for repair, the vendor will be reimbursed for the manufacturer's invoice plus an additional $15. Please attach a copy of the manufacturer's original invoice to the request. If the repair was completed by the vendor directly, the vendor will be reimbursed for the vendor's invoice which should include the cost for time and parts plus an additional $15. ☐

05 - 20 Vision Care Services for Traditional Clients (Clarification to MIB 03-01)

On January 15, 2003, Vision Care benefits were reduced for non-pregnant Traditional Medicaid clients. This was only a reduction and did not eliminate Vision Care benefits.

As clarification, all Traditional clients still have coverage for eye examinations and care to identify and treat medical problems such as diabetic retinopathy, glaucoma, cataracts, etc

SUMMARY OF VISION CARE BENEFITS

Benefit	Traditional Medicaid Plan (Purple Card)
Vision exams	Only children up to age 21 and pregnant women are covered for eye exams to determine refractions*. Eye exams to determine refractions* are not covered for adults age 21 and older.
Eyeglasses	Only children up to age 21 and pregnant women are covered for glasses (lenses and frames). Eyeglasses (lenses and frames) are not covered for adults age 21 and older.
Care for medical problems of the eye	Eye exams and eye care to identify and treat medical problems (such as diabetic retinopathy, glaucoma, cataracts, etc.) are covered for all clients.

*prescription for glasses ☐

05 - 21 Injectable Medications List, HCPCS 2005 Coding Changes

Long Description Change: J0150

2005 Discontinued Codes:
Effective for dates of services on or after January 1, 2005, the following codes are discontinued:
J3245 Tirofiban hydrochloride, 12.5 mg
J3395 Verteporfin, 15mg
J7618, J7619 Albuterol, all formulations ☐

05 - 22 General Attachments for the Utah Medicaid Provider Manual Updated

Three documents in the General Attachments Section of the Utah Medicaid Provider Manual have been changed:

- The Insurance Payment Report Claim Attachment and Instructions are removed, as these are no longer required.
- The Guide to Medical Interpretive Services was updated as of October 2003.* Refer to Bulletin 05 - 24, Interpretive Services.
- The telephone number lists for Medicaid Prepaid Mental Health Plans and Managed Care Plans are updated to January 2005.* Refer to Bulletin 05 - 23, Phone Number List for Managed Care Plans Updated.

* The new document is on-line. Use the link to the Medicaid Manual on the Medicaid Provider's web site: http://health.utah.gov/medicaid/html/provider.html ☐

05 - 23 Phone Number List for Managed Care Plans Updated

The phone number list for Managed Care Plans, including Prepaid Mental Health Plans (PMHP), has been updated. The new list is on-line at http://health.utah.gov/medicaid/pdfs/phonelist.pdf. Changes include the following:

County	PMHP	Telephone, Main Office	Prior Auth., inpatient mental health
Salt Lake, Summit, Tooele	Valley	(801) 263-7100	All Hours, Children: 801-264-2325 Business Hours, Adults: 801-565-6998
Utah	Wasatch	(801) 373-4766	All Hours: 801-373-7393
Piute, Juab, Wayne, Millard, Sanpete, Sevier	Central Utah	(435) 462-2416 After Hours: 1-877-386-0194	After Hours: 1-877-386-0194 Business Hours: 435-462-2416 After Hours, Adults: 801-261-1442
Weber, Morgan, Davis and Utah counties: area code is **801**			

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05 - 24 Interpretive Services

The following article is a reprint of an article that originally appeared as article 03- 82 Interpretive Services in the October 2003 Medicaid Information Bulletin.

The Division of Health Care Financing has contracted with four companies to provide interpretive services to Medicaid, CHIP and PCN clients who have Limited English Proficiency (LEP). These contracts make interpretive services available by phone 24 hours a day, 7 days a week, 365 days a year, without prior appointment. The telephone services cover almost 180 spoken languages. Additionally, the number of interpreters who are available for scheduled, in-office interpretive services, has increased. The contractors have demonstrated a high level of commitment to professional/ethical standards, to cultural sensitivity and to high standards for training and testing of medical terminology, which enables them to provide a superior level of service for clients.

The contracts cover interpretive services for Medicaid, CHIP, and PCN clients who are not enrolled in a Managed Care Plan (MCP), or for carve out services including dental, pharmacy and chiropractic care. Clients who are members of an MCP must use the interpretive services offered by the MCP, except for the carve out provision described above. Clients who are members of a Prepaid Mental Health Plan (PMHP) should continue to use the interpretive services provided by the Plan. Interpreters will only be provided for services normally covered by the program for which the client is eligible, to include setting up appointments.

Details on how to access these services and the information that is needed for billing purposes can be found on the Medicaid web site: http://health.utah.gov/medicaid/provhtml/interpreter.html. You may also contact the Medicaid Information Line for instructions on obtaining these services. ☐

05 - 25 Pharmacy Manual Revisions

Coverage of Services, Investigational use drugs
The requirement for supplying documentation supporting investigational use of drugs is changed from six weeks in advance of the next scheduled DUR meeting to two weeks. (Chapter 2-5B, Investigational Use).

Prior Authorization Process - Physician initiated
Because the information necessary for requesting prior approval resides with the physician, prior approval requests must be made by the physicians office.

Drug Recycling Program, Nursing Homes and LTC facilities - Discontinued
Effective January 1, 2005, the Drug Recycling program will be discontinued. Nursing homes and Long Term Care facilities will no longer be required to return unused medications to the pharmacy. Pharmacies will no longer receive credit for returned medications.

Compounded Prescriptions- billing process updated to match current programming
Claims for compounded prescriptions can be accepted for multiple ingredients per prescription number. Dispensing fees will be paid only for covered ingredients. Up to a maximum of three (3) dispensing fees will be allowed per prescription with covered ingredients, unless fewer than three (3) covered ingredients are used in which case the number of dispensing fees will only equal the number of covered ingredients. All ingredients must be included on the claim, even those that are not eligible for a dispensing fee. The quantity of each ingredient must be included. Reimbursement is made only for the measured quantity used; incorrect quantities will invalidate the claim. The patient will be charged one co-pay per covered ingredient up to a maximum of five (5).

Levothyroxine products
Effective July 28, 2004, therapeutic ratings for levothyroxine products were updated in the FDA Orange Book. The FDA has, for the first time, assigned multiple therapeutic ratings to the same product. Many of these products have been given a “three-character code” (AB1, AB2, or AB3), and only drugs with the same three-character code are considered to be therapeutically equivalent and therefore substitutable. A new table showing the FDA ratings for the available Levothyroxine products is presented:

Trade Name	Labeler	Theraputic Equivalent Code
Unithroid	Stevens	AB1, AB3
Levothyroxine Sod.	Mylan	AB1, AB2, AB3
Levoxyl	Jones Pharma	AB1, AB3
Synthroid	Abbott	AB2
Levo-T	Ala Pharm	AB2, AB3

State and Federal regulations require that generic branded drugs be dispensed whenever such an equivalent is available. This presents a potentially confusing situation where attention must be given to the appropriate selection of product when prescriptions for levothyroxine are involved.

Accordingly, prescriptions dispensed for levothyroxine products would require the use of the appropriate generic equivalent product unless medical necessity is demonstrated as per established Medicaid guidelines.

Prescription limit- 7 prescriptions per month Threshold
Seven (7) or more prescriptions per month triggers a Drug Utilization Review for Medicaid recipients.

Administration of medication in Doctors Office - need for NDC code coming
In anticipation of the future day when the NDC code will be required in addition to the appropriate J-code for the billing of medications administered in the doctors office, please be aware that the NDC code can be submitted with electronic billings now. It is recommended that doctors offices begin using NDC numbers with their billings so that the transition is made easier.

Cumulative 30 day quantities
The cumulative 30 day amount for the following drugs is identified:

Cumulative monthly amounts are determined for the following drugs:

a. Celebrex - 60
b. Bextra - 30
c. Carisoprodol (Soma) - 120
d. Detrol LA - 30
e. Sedative-Hypnotics - 30
f. Oral APAP/narcotic combinations - 180
g. Methadone any strength - 150
h. Actiq - 120
i. Duragesic 25, 50, & 75mcg - 15
j. Morphine long acting formulations, any strength - 90
k. Oxycontin or generic, any strength - 90
l. PPIs - 31 with prior approval for override.
m. Stadol NS - 10ml (4 vials)
n. Tryptans (for migraine headache) - 9
o. Ultram and generics - 180
p. Ultracet 180 (focus on APAP, therefore included in oral APAP/narcotic 180 cumulative limit)
q. Viagra, Cialis, Levitra - 5
r. Miralax - 1054 gm
s. Lactulose - 1800 ml

Criteria for Use of Synagis
Criteria for Coverage Through Physician's Office
A physician may prescribe and dispense Synagis to Medicaid clients **in his/her office** with a prior authorization as long as the following criteria are followed:

– The patient does not have active RSV (respiratory syncytial virus) infection, and is at serious risk for contracting RSV**, AND** either criteria A **OR** criteria B below.

A. The patient had ≤ 35 weeks gestation, and is six months of age or younger , **OR**

B. The patient is less than 25 months of age **AND**:
1. The patient has had a clinical diagnosis of BPD (Broncho pulmonary dysplasia) requiring ongoing medical treatment within the last six months, **OR**
2. The patient has been on supplemental oxygen within the last six months, **OR**
3. The patient has had in the last six months either:
   – steroids
   – bronchodilators
   – diuretics, OR
4. The patient has a clinical diagnosis of a hemodynamically significant congenital heart disease.
5. There is a limit of no more than five doses per 12 month period administered once a month for five consecutive months.
6. A child who has started the series and then turns age two may finish the series.
7. Bill using CPT code 90378 for 50mcg.

Criteria For Coverage Through Pharmacy
Records supporting these criteria must be maintained in the physician's office and are subject to post payment audit.

Prescriptions administered through a home health agency and **not** administered in a physician's office require a prior approval. The prior approval will be issued to a pharmacy based only on the documentation submitted by a physician. In addition to the criteria identified above, the patient must meet the following additional criteria before a prior authorization approval will be issued:

1. Must be home-bound.

2. Bill using correct NDC numbers.

If a prior authorization request which does not meet the above criteria has been denied, the denial may be appealed to the Drug Utilization Review Committee (DUR) by the requesting physician, with supporting documentation. The physician appealing the decision will need to either attend the next scheduled DUR meeting to answer questions related to the appeal or send in sufficient information to answer any questions the Committee may have regarding the request.

□